In order for _____ to complete his/her eligibility determination so that he/she may receive services at the clinic, the bottom portion of this letter needs to be completed and returned to us.

We appreciate your cooperation in this matter and wish to assure you that all information you give us will be kept confidential.

This is to certify that (employee's name)_____ has worked for (employer)_____ since ___/___/____. He/she works _____ hours per _____ and earns $_____ before taxes are deducted.

Signature of Supervisor/Employer_____

Title _____

Address of Employer _____
_____

Phone Number of Employer _____